period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under §405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under §405.1885 of this chapter.

[54 FR 40316, Sept. 29, 1989; 55 FR 290, Jan. 4, 1990, as amended at 56 FR 43243, Aug. 30, 1991; 57 FR 39830, Sept. 1, 1992; 58 FR 46343, Sept. 1, 1993; 59 FR 45401, Sept. 1, 1994; 60 FR 63189, Dec. 8, 1995; 61 FR 46225, Aug. 30, 1996; 62 FR 46034, Aug. 29, 1997; 63 FR 26358, May 12, 1998; 63 FR 41005, July 31, 1998; 64 FR 41542, July 30, 1999; 65 FR 47049, 47109, Aug. 1, 2000]

§413.87 Payments for Medicare+Choice nursing and allied health education programs.

(a) *Statutory basis.* This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

(b) *Scope.* This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under §413.85.

(c) *Qualifying conditions for payment.* For portions of cost reporting periods occurring on or after January 1, 2000, a hospital that operates and receives payment for a nursing or allied health education program under §413.85 may receive an additional payment amount. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraph (c)(1) and (c)(2) of this section are met.

(1) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under §413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program and receives reasonable cost payment for the program as specified under §413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(2) of this section.

(2) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under §413.85 in the current calendar year.

(d) *Calculating the additional payment amount.* Subject to the provisions of paragraph (f) of this section relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

(1) *Step one.* Each calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

(2) *Step two.* Determine the ratio of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

(3) *Step three.* Multiply the ratio calculated in step two by the amount determined in accordance with paragraph (e) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

(e) *Calculation of the payment ''pool.''* (1) Subject to paragraph (e)(3) of this section, each calendar year, HCFA will calculate a Medicare+Choice nursing and allied health payment ''pool'' according to the following steps:

(i) Determine the ratio of projected total Medicare+Choice direct GME payments made in accordance with the provisions of § 413.86(d)(3) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.

(ii) Multiply the ratio calculated in paragraph (e)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made across all hospitals in the current calendar year.

(2) The resulting product of the steps under paragraph (e)(1)(i) and (e)(1)(ii) of this section is the Medicare+Choice nursing and allied health payment pool for the current calendar year.

(3) The payment pool may not exceed $60 million in any calendar year.

[65 FR 47051, Aug. 1, 2000]

§ 413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

(a) *Statutory basis.* This section implements section 1886(h)(6) of the Act, which establishes a program under which incentive payments may be made to qualifying entities that develop and implement approved plans to voluntarily reduce the number of residents in medical residency training.

(b) *Qualifying entity defined.* ''Qualifying entity'' means:

(1) An individual hospital that is operating one or more approved medical residency training programs as defined in § 413.86(b) of this chapter; or

(2) Two or more hospitals that are operating approved medical residency training programs as defined in § 413.86(b) of this chapter and that submit a residency reduction application as a single entity.

(c) *Conditions for payments.* (1) A qualifying entity must submit an application for a voluntary residency reduction plan that meets the requirements and conditions of this section in order to receive incentive payments for reducing the number of residents in its medical residency training programs.

(2) The incentive payments will be determined as specified under paragraph (g) of this section.

(d) *Requirements for voluntary plans.* In order for a qualifying entity to receive incentive payments under a voluntary residency reduction plan, the qualifying entity must submit an application that contains the following information, documents, and agreements—

(1) A description of the operation of a plan for reducing the full-time equivalent (FTE) residents in its approved medical residency training programs, consistent with the percentage reduction requirements specified in paragraphs (g)(2) and (g)(3) of this section;

(2) An election of the period of residency training years during which the reductions will occur. The reductions must be fully implemented by not later than the fifth residency training year in which the plan is effective;

(3) FTE counts for the base number of residents, as defined in paragraph (g)(1) of this section, with a breakdown of the number of primary care residents compared to the total number of residents; and the direct and indirect FTE counts of the entity on June 30, 1997. For joint applicants, these counts must be provided individually and collectively;

(4) Data on the annual and cumulative targets for reducing the number